RESET

Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

WORKER VERIFICATION FORM

Unit	Work Position
Claim number	
Date of request	
Date of injury	

Name	Phone number
Address	
City	State ZIP

If your address or phone number is incorrect, please correct it in this box.

For us to consider paying you time-loss benefits, we must have this information. Complete the statements that apply to your situation. Please sign and return this form within 14 days.

The department will rely, in part, on your statements in this document to determine your benefits. Your statements may change time-loss monthly benefits.

Persons making false statements in obtaining industrial insurance benefits are subject to civil and/or criminal penalties under the law.

I have not worked nor was I able to work due to a work-related injury/illness from _____ to

I will/did return to work on (This includes any type of work including self-employment, COPES or CHORE Services.)

I am working ☐ Full time ☐ Part time for hours a day

I have applied for the following benefits ☐ Unemployment ☐ Food Stamps only ☐ Other Public Assistance programs

If your employer was contributing to your and/or your family's medical, dental and/or vision insurance and you had coverage on the day of injury, do you still have employer-paid coverage? ☐ Yes ☐ No

If not, when did employer-paid coverage end?

I understand I am to immediately report to my claim manager if I return to any work or my doctor releases me for work; or if I am incarcerated or under sentence by order; or if there are any changes in custody of the children. I understand that I am responsible for notifying the department as these changes can affect my compensation benefits.

I certify the above statements are true and correct.

Date	Worker's signature	Phone #